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AUTHOR Maiden, Robert J.
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ABSTRACT

The potential for feelings of hopelessness and depression in the aged is well documented. Although studies have examined the role of perceived control in ameliorating depression in the institutionalized elderly, no research has actually measured the perceived causal attributions among depressed, hopeless and/or institutionalized elderly populations. To explore the different types of attributional styles used by depressed/nondepressed elderly women (N=50), the old and the reformulated models of learned helplessness were tested. Pretest scales included the Zung Depression Scale, the Gallagher Well-Being Scale, the Rosenberg Self-Esteem Scale, the Rosow and Breslau Health Scale, the Information subtest of the Wechsler Adult Intelligence Scale, and the subject's education level. Subjects were presented with a Thematic Apperception Test card depicting a success/failure situation and were asked to determine the degree to which task difficulty, luck, effort, and ability contributed to the respective outcomes. Data analysis revealed significant interactions on the luck and ability variables, which upheld the reformulated model predictions that depressed subjects would attribute success to an external agent and failure to an internal agent and nondepressed subjects would attribute failure to an external agent and success to an internal agent. The principle implication is that depression may be reversed by replacing maladaptive cognitions with more vital ones, suggesting that treatment for depression in the elderly should continue to be cognitive therapy. (Tables of data analyses are included in the appendices). (NRB)

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THE ATTRIBUTION OF UNIVERSAL OR PERSONAL HELPLESSNESS IN NONDEPRESSED AND DEPRESSED ELDERLY FEMALES

Robert J. Malden
~~Saint Bonaventure College~~
Alfred University

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of the Eastern Psychological Association,
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The potential for feelings of hopelessness and depression in the aged is well documented. Research has shown that, as people grow older, they often express great concern about aging and consider themselves as depressed and pushed aside (Kogan and Shelton, 1962). Also, as many authors have noted (see Botwinick, 1978, for a review), the aged are particularly susceptible to loss of control over environmental events. For example, Shanas (1965) reported that many of the elderly have difficulty in climbing stairs (26%), in bathing themselves (9%) and in dressing themselves (7%). In addition, the elderly may feel less in control because their sense organs are less acute. Granick et al. (1975) reported that even normal hearing loss occuring in a healthy aged population led to social withdrawal and greater irritableness. Moreover, the elderly are more likely than younger populations to suffer the devastating effects of loosing a spouse or one of their children. (Brown, 1961).

Although the aged comprise slightly more than 10% of the population in the United States, they constitute more than one-fourth of the suicides (Patterson, Abrahans, and Baker, 1974). This figure is believed to be conservative, because many suicidal deaths go unreported. Since death is expected in old age, other factors are often cited as the cause. Also not included are deaths accomplished indirectly by ignoring safety rules, not

taking necessary medicine or neglecting one's health and well-being. These deaths may be considered "subintentional" suicides. Moreover, because the negative consequences of the normal processes of aging are emphasized (Tuckman & Lorge, 1953, Lawton, 1975), fewer attempts are made to resuscitate the elderly, especially those known to have attempted suicide (Crandall, 1980).

The leading cause of suicide is depression. According to Bensen and Brodie (1975), 80% of the aged who are disposed to commit suicide are depressed. Thus, with larger numbers and a greater proportion of our population expected to enter elderly standing in the next few decades, it becomes increasingly more important for researchers to examine the effects and to locate the sources of depression. This statement is true even if the actual percentage of depression in the elderly remains at the same figure, i.e., 10% to 15%.

Recognizing this, two relatively recent studies have examined the role that perceived control plays in ameliorating depression in institutionalized elderly.

In the first study, Schulz (1976) increased the predictability of a new environment for relocated nursing home residents. He simply gave the relocated residents pertinent information about their new home, such as the "schedules and routines within the hospital, the facilities and services available to them, their locations

within the institutions, and directions on how to get to different areas of the hospital." A control group received little or no information about their new environment. Schulz's findings were clear: Predictability was found to be the key mechanism in maintaining a splendid sense of well-being in the relocated residents.

In the same vein, a recent study by Langer and Rodin (1976) looked at the effects of perceived responsibility in nursing home residents. They emphasized the residents' responsibility for controlling and regulating their space within the home. For the control group, the authors emphasized the staff's responsibility for controlling and maintaining the residents' areas. Afterward, the responsible residents were given a number of small tasks to do such as taking care of plants, while the staff performed these duties for the control or dependent residents. According to nurses' ratings the residents who were made accountable for their environment were judged to be happier, to be more effective and to be in greater psychological and physiological health. After the completion of this study, follow-up measures 18 months later revealed that the benefits of the studies were still being maintained (Rudin & Langer, 1977).

Schulz (in press) proposed viewing the above research from the vantage point of attribution theory. Thus, the responsible residents can be seen as making positive

self-attributions regarding their ability to control outcomes within the nursing homes. In Weiner et al.'s terms (1971), the controlling residents made an internal/stable attribution regarding their mastery of their environment which persisted over time. In Meichanbaum's terms (1977), the residents' "inner speech" included the sentence: "I have the ability to control my place of residence."

Regrettably, there is no research of which I am aware that actually measured the preceived causal attributions among depressed, hopeless and/or institutionalized elderly populations.

The purpose of this paper is to explore the different types of attributional styles which are used by depressed/nondepressed elderly women.

Two contrasting models of depression were tested: the old model versus the reformulated model of learned helplessness. The old model (Seligman, 1975) predicts main effects, i.e., nondepressed individuals are more likely than depressed individuals to ascribe all success/failure outcomes to internal factors, while depressed individuals are more likely than nondepressed individuals to ascribe them to external factors. The reformulated model incorporated attribution theory (Abramson, Seligman & Teasdale, 1978) and predicts interaction effects, i.e., nondepressed individuals are more likely than depressed individuals to ascribe their failures to external causes (I'm not responsible) and their successes

to internal factors (I am responsible). Contrastingly, depressed individuals are more likely than nondepressed individuals to attribute their failures to internal causes (I am responsible) and successes to external factors (I'm not responsible). This of course results in differential levels of self-esteem -- i.e., high for nondepressed and low for depressed. (See Appendix I)

The study also examined the question of whether or not the subjects would generalize similar causal attributions to others as they ascribed to themselves for the same outcome. The reformulated model predicts that nondepressed individuals should generalize the same attributions to others as they ascribed to themselves for failure. It states that when nondepressed individuals are faced with failure, they feel universally helpless. That is, they believe that they, as well as everybody else, would fail on the task. The reformulated model predicts, however, that depressed individuals would not generalize causal attributions to others similar to those ascribed to themselves. Depressed subjects, when confronted with failure, feel personally responsible. That is, they believe only they and nobody else would fail on the task.

The subject pool consisted of 50 elderly females. They were paid volunteers whose ages ranged from 65 to 96 years old, with a mean age of 76 years. They were white, residents of the Philadelphia - Coatesville area,

and were representative of many socio-economic and ethnic backgrounds. They were for the most part of high intelligence. Most had finished high school and many had some college experience. The mean IQ of the Information subtest score was 12.8, which is equivalent to approximately 115 using the WAIS norms for their representative age group (Wechsler, 1955).

A number of pretest scales were used to assess individual differences on a variety of variables. The measures included the Zung Depression Scale (1965), the Gallagher Well-Being Scale (Gallagher et al., 1978), the Rosenberg Self-Esteem Scale (1965), the Rosow and Breslau Health Scale (1966), the Information subtest of the WAIS, and the subject's education level.

The first part of the study examined the causal ascriptions given for experiencing success/failure on an impersonal number guessing task. The second part of the study examined the subject's generalization of their causal ascriptions for success/failure outcomes to others. The subjects were presented with a Thematic Apperception Test (Bellak, 1975) card that depicted a success/failure situation, and they were asked to determine the causal reasons for the specific outcome. Causal ascriptions throughout the study were measured by a standard questionnaire that required the subject to rate on a 1-5 scale the degree to which each of four factors -- task difficulty, luck, effort, and ability -- contributed to the respective outcomes.

A 2 x 2 univariate analysis as a function of depression and outcome with health and IQ as covariates was carried out on the four attribution scales. It revealed significant interactions on the luck and ability variables, $F(1, 32) = 4.279$, $p < .04$, $F(1, 32) = 4.951$, $p < .03$, respectively. To more clearly discriminate between the depressed and non-depressed groups, twelve subjects who scored in the middle range of the depression scale were dropped. The findings upheld the reformulated model predictions that (a) depressed subjects would attribute success to an external agent (luck), (b) depressed subjects would attribute failure to an internal agent (level of ability), (c) nondepressed subjects would attribute failure to an external agent (luck), and (d) nondepressed subjects would attribute success to an internal agent (level of ability). (See Table 1 for mean ratings).

With respect to the second part of the study, a 2 x 2 univariate analysis of repeated measures as a function of depression and outcome with health and IQ as covariates was carried out across the four dependent variables -- task difficulty, luck, effort, and ability. The reformulated model's proposed constructs of personal helplessness and universal helplessness are consistent with the findings. Depressed subjects behaved as though they were personally helpless in that they attributed the failure of others to external factors; they attributed their own failure to internal factors. In comparison,

nondepressed subjects behaved as though they were universally helpless in that they attributed their own failure as well as the failure of others to external factors. (See table 2 for mean ratings.)

An invidious cycle is apparent. Depressed people with low self-esteem manifest an attributional style that consistently guarantees a poor self-concept which in its turn dictates a maladaptive attributional style which next maintains, or if possible even lowers, their already low self-esteem. Once caught within this vicious, deepening whirlpool, depressed people may find that they cannot escape without outside help.

The principal implication is that depression may be reversed by replacing maladaptive cognitions with more vital ones. This process should result in: first, a positive shift in level of self-esteem; second, higher spirits; and finally, more optimistic interpretations of success/failure experiences.

In sum, to treat depression, its cognitive/perceptual processes must be reorganized and their directional flow reversed from pessimistic expectations to positive ones.

Cognitive therapy is the psychological method of choice in treating depression (Klerman, 1978). Of their various cognitive approaches, Bandura's (1977) mastery or efficacy training has the greatest therapeutic potential for treating depression in the elderly. Mastery training, however, will be insufficient if the depressed individuals'

underlying causal perceptions for success/failure experiences remain untouched. The necessary research to probe these issues needs to be done.

As a final point, it should be mentioned that sex differences in learned helplessness and depression have been found (Radloff, 1979). Also, elderly depressed males who had undergone similar procedures as above perceived different causes than females for their success/failure outcomes (Maiden, 1980). The important point remains that for both sexes cognitive interpretations played a central role in maintaining their level of affect. Thus, on the broadest and most general level, the interpretation for perceived success/failure outcomes will vary as a function of level of affect, gender, and self-concept. Treatment for both sexes should continue to be cognitive. However, the sex and personality of the elderly individual may determine on which particular set of causal attributions the therapists focus their attention.

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TABLE 1

Mean Ratings on the Four Attribution Variables and Health and IQ According to Depression Level and Outcome Given for the Performance Task By Females

	Task Difficulty	Effort	Luck	Ability	Health	IQ
Non-depressed						
Success	1.80	4.10	2.90[a]	3.20[a]	4.0	11.8
Failure	1.60	2.70	3.60[a]	2.20[a]	5.2	12.2
Depressed						
Success	2.00	3.13	4.13[a]	2.88[a]	2.5	12.5
Failure	3.00	2.40	2.60[a]	3.80[a]	2.7	13.2

Note: The larger value equals greater causal attribution.

Females (N=38, 10 per cell, except for depressed-success where N=8)

[a]Indicates, according to the analyses of variance reported in Table 15, significant interactions ($p<.05$).

TABLE 2

Mean Attribution of Depressed Nondepressed Females as a Function of Outcome, For Themselves and For Others.

	Dependent Measures			
	Task Difficulty	Effort	Luck	Ability
Groups:				
ND/F				
Self	1.60	2.70	3.60	2.20[a]
Other	3.40	1.60	2.80	2.90[a]
D/F				
Self	3.00	2.40	2.60	3.80[a]
Other	3.20	1.10	1.90	2.80[a]
ND/S				
Self	1.80	4.10	2.90	3.20[a]
Other	2.60	4.60	3.20	4.90[a]
D/S				
Self	1.80	3.40	4.20	2.90[a]
Other	1.70	4.90	3.10	4.90[a]

Note: N= 40, with 10 subjects per cell.
Two subjects with depression scores (21) slightly above the mean (20) were added to attain equal N in all cells to better perform repeated measures analyses.

a Indicates, according to the Analysies of Variance reported in Appendix III, a directional A X B X C interaction effect.

APPENDIX I

PREDICTED CAUSAL ATTRIBUTION MADE BY NONDEPRESSED/DEPRESSED PEOPLE ACCORDING TO THE OLD AND REFORMULATED MODEL OF LEARNED HELPLESSNESS

	Attribution Made	
	Old Model	New Model
Depressed		
Success	External	External
Failure	External	Internal
Nondepressed		
Success	Internal	Internal
Failure	Internal	External

APPENDIX II

Multivariate Analysis of Variance of Causal Ascriptions as a Function of Depression and Outcome With Covariates Health and IQ for Females

Part I: (Performance Task)

Measure	Depression (A)	Outcome (B)	A X B
Univariate *df*	(1,32)	(1,32)	(1,32)
Task Difficulty	1.367	.743	1.955
Effort	2.328	4.171*	.364
Luck	.023	.190	4.279*
Ability	1.994	.142	4.951*
Multivariate F Wilks Lambda (*df* 4,29)	1.232	1.228	1.848
Average F (*df*=4,29)			1.889*

Note: * $p < .05$

APPENDIX III

Analysis of Variance Based on the Causal Ascription Given for the Performance Task to Another Person For the Same Outcome.

Part II: (Procedure #2 - Females on Ability With Health and IQ as Covariates).

Source:	df	MS	F	Sign.
Within				
Residual	34	1.532		
Regression	2	.000	.000	
Self att. vs other att.	1	14.450	9.429	$p<.004$
Depression A X C	1	2.450	1.598	
Outcome B X C	1	20.000	13.051	$p<.0009$
A X B X C	1	5.000	3.262	$p<.08$
Between				
Error 1	34	1.746		
Regression	2	2.264	1.296	
A	1	1.649	.944	
B	1	17.997	10.306	
A X B	1	3.873	3.218	

A = Depression
B = Outcome
C = Self attribution versus perceived attribution for other person receiving the same outcome experience.

APPENDIX IV

Analysis of Variance Based on the Causal Ascription Given for the Performance Task to Another Person for the Same Outcome.

Part II: (Procedure #2 - Females on Task Difficulty With Health and IQ as Covariates).

Source:	df	MS	F	Sign.
Within				
Residual	34	2.172		
Regression	2	.000		
Self att. vs other att. C	1	9.112	4.195	$p < .05$
Depression A X C	1	7.812	3.596	$p < .07$
Outcome B X C	1	2.112	.972	
A X B X C	1	.612	.281	
Between				
Error 1	34	1.390		
Regression	2	.479	.344	
A	1	.067	.048	
B	1	13.122	9.434	
A X B	1	4.66	3.354	

A = Depression
B = Outcome
C = Self attribution versus perceived attribution for other person receiving the same outcome experience.